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CHAMPUS Mental Health Demonstration Project in Virginia

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The Honorable Beverly B. Byron
Chairman, Subcommittee on Military Personnel
and Compensation
Committee on Armed Services
House of Representatives

The Honorable Herbert H. Bateman
Ranking Minority Member, Subcommittee on Military
Personnel and Compensation
Committee on Armed Services
House of Representatives

This report responds to your request that we examine the Contracted Provider Arrangement managed care demonstration project for mental health services currently being conducted in the Tidewater, Virginia, area by the Department of Defense (DOD) for beneficiaries of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).[1] CHAMPUS beneficiaries in several Virginia cities, including Norfolk, Portsmouth, and Newport News, participate in the project. For a fixed-price ($31.2 million in fiscal year 1992), the project's contractor is responsible for authorizing, arranging, and paying claims for mental health care services to CHAMPUS beneficiaries who seek care in the project area.

In November 1991, the Tidewater area media began reporting allegations that the project's contractor was denying needed care for CHAMPUS beneficiaries to increase its profits under the fixed-price arrangement. Subsequently, your Subcommittee held a hearing on the project in April 1992. At the conclusion of the hearing, you asked us to provide a report (1) identifying the extent of cost-savings achieved under the project and explaining how these savings were achieved and (2) describing the extent to which DOD oversight and contractor controls have been sufficient to ensure that CHAMPUS beneficiaries have access to quality treatment.

Background

Since 1983, DOD has designed and implemented a number of initiatives to control mental health care costs. The Contracted Provider Arrangement project was one of DOD's first attempts to use managed care to provide mental health services. DOD selected the Tidewater area of Virginia as the

[1]CHAMPUS pays for a substantial portion of the health care that civilian hospitals, physicians, and other providers give to DOD beneficiaries. Retirees and their dependents, dependents of active-duty personnel, and dependents of deceased members receive care from these providers if they cannot obtain it at military facilities.

site for the project because CHAMPUS mental health care costs per capita in the area were nearly twice the CHAMPUS national average.

The project began in fiscal year 1987 and is scheduled to expire at the end of fiscal year 1993. Two different companies have managed the project since its inception. The first, Sentara First Step, managed the project from October 1986 through March 1989. DOD competitively re-bid the contract and awarded it to the current contractor, First Hospital Corporation (FHC), for a total cost of about $143 million. FHC began managed care operations for mental health services on April 1, 1989.

The demonstration project has several key features:

- mandatory face-to-face assessments (except for psychiatric emergencies) of beneficiaries' mental health needs before authorization of mental health care services;
- contractor on-site review of inpatient medical records to assess the need for continued hospitalization;
- a broad range of mental health care settings, including acute hospitalization, residential care for children and adolescents, partial hospitalization, outpatient, and intensive outpatient care;[2] and
- a network of professional providers and facilities with discounted rates of reimbursement.

DOD recognized from the outset of the demonstration that the project, with its fixed-price contract, could encourage a contractor to increase profits by restricting care where possible. To address this concern, DOD contracted with SysteMetrics[3] to monitor the project and report any potential quality of care problems to DOD.

Scope and Methodology

Our work focused primarily on efforts by DOD and FHC to identify, document, and manage mental health care needs and benefits in the project area. In this regard we reviewed:

[2]Partial hospitalization is a level of care between outpatient and inpatient care in which beneficiaries spend a portion of each day in an inpatient setting. Intensive outpatient treatment allows beneficiaries to exceed the normal CHAMPUS limit of two outpatient visits per week.

[3]SysteMetrics is a national research and consulting firm specializing in health policy and services research and health care database development. Among its many other projects, SysteMetrics monitors the accuracy of medical determinations made by peer review organizations for Medicare beneficiaries (the SuperPRO project).

- DOD monitoring and oversight activities, including contract evaluations and the work of SysteMetrics;
- FHC policies, procedures, and controls over the various processes, such as intake, quality assurance, provider and beneficiary relations, appeals and complaints, and management information systems;
- the criteria FHC uses to determine the appropriate care setting for treatment;
- the professional backgrounds and experiences of FHC staff who make care decisions; and
- documents pertaining to utilization of services, contract and benefit costs, savings, project evaluation, and quality of care.

We supplemented these data with discussions with officials in the Office of the Assistant Secretary of Defense (Health Affairs), CHAMPUS, FHC, and SysteMetrics. Also, we discussed quality and access issues with beneficiaries, their representatives, local hospital administrators and mental health practitioners, and state and local mental health officials. We did not make clinical assessments of the quality of care given by providers or the appropriateness of specific care decisions made by FHC. Our work was conducted between April 1992 and November 1992 in accordance with generally accepted government auditing standards.

Results in Brief

The project has saved money as indicated by two separate measures of cost savings: (1) current mental health care costs in the Tidewater area compared with preproject costs, and (2) an estimate of what mental health care costs in the area would have been in the absence of any managed care project. From the project's beginning in fiscal year 1987 through fiscal year 1991, annual CHAMPUS mental health care costs in the area have averaged $32 million, including the fixed-price contract, compared to $37 million in benefit costs in fiscal year 1986, the year before the project began. Secondly, a DOD estimate, which we adjusted to reflect previously unaccounted-for costs, such as for the project's start-up, shows that through fiscal year 1991 mental health care costs in the Tidewater area would have been about $148 million more if mental health costs had continued to grow at the same rate as CHAMPUS's nationwide mental health costs.

Project savings were primarily achieved in two ways. This was done by (1) reducing the use of inpatient services by about 83 percent and substituting less expensive partial hospitalization and outpatient treatment and (2) paying mental health providers lower reimbursement rates.

DOD oversight and contractor controls have been insufficient to ensure that CHAMPUS beneficiaries have access to quality treatment. While DOD effectively monitors the administrative aspects of FHC's operations, it has not provided for effective (1) independent evaluation or (2) quality-of-care monitoring of the project. Similarly, while FHC's system for assessing and authorizing care has many favorable features that help beneficiaries obtain care, it also has several potential weaknesses that may unduly restrict access to care and limit identification of quality treatment problems.

Principal Findings

Project Has Saved Money Under Two Measures of Cost Savings

Two different measures of savings, one of actual expenditures and the other an estimate of cost growth in the project area without the project, indicate that savings have been achieved. First, total costs in the Tidewater project area were less in fiscal year 1991 than in 1986. In 1986, the year before the demonstration project began, mental health benefit costs in the area were about $37 million, excluding claims administration and processing costs. From the project's beginning through fiscal year 1991, total costs decreased annually and averaged about $32 million each year. This amount includes the fixed-price contract and claims administration and processing costs.

Second, DOD has saved about $148 million based on the assumption that in the absence of the managed care project annual costs in the Tidewater area would have increased at the same rate as CHAMPUS's nationwide costs. Nationwide, CHAMPUS's mental health care costs increased 101 percent from fiscal year 1987 through fiscal year 1991.

DOD has estimated savings of $179 million during this period, but its estimate is overstated for several reasons. For example, it excludes project start-up costs of about $2 million. Also, DOD's estimate excludes about $6 million of care provided to eligible beneficiaries who received care outside the project area. These costs are paid by DOD, not the contractor. Further, DOD's estimate includes $23 million in savings under the first contract for avoiding costs that were not even the project's liability—the costs of care provided to beneficiaries who lived outside the Tidewater area but who came into the project area for treatment.

Project Savings Attributed to Shifting Utilization Patterns and Reduced Reimbursement Rates

The project's savings are attributable to (1) shifts in utilization patterns from inpatient services to less expensive partial hospitalization and outpatient services and (2) reductions in provider reimbursement rates. Inpatient costs, (excluding partial hospitalization) as a percentage of total costs, decreased from 85 percent in fiscal year 1986, to 32 percent in fiscal year 1991. Admissions for inpatient services decreased 44 percent, the average length of stay for an inpatient admission decreased 70 percent, and the average cost of an admission declined 76 percent. On the other hand, outpatient visits increased 74 percent and partial hospitalization admissions offset almost all of the decrease in inpatient admissions. In total, the benefit payments for inpatient and outpatient services decreased from $37 million in fiscal year 1986 to $15 million in fiscal year 1991.

In addition, fiscal year 1991 average reimbursement rates in the project area were lower than 1986 rates and also were lower than the 1991 national rates for CHAMPUS. For example, in 1991, the average inpatient daily reimbursement cost (excluding partial hospitalization) in the project area was 19 percent less than the 1986 average inpatient daily reimbursement cost in the area. Similarly, the average reimbursement for an outpatient visit was 9 percent less in 1991 compared with the same cost in 1986. Also, the 1991 average inpatient and outpatient costs (excluding partial hospitalization) in the project area were 21 percent and 20 percent lower than comparable 1991 national average costs, respectively. These cost and utilization data are shown in more detail in appendix I.

Improvements Needed in DOD Oversight

DOD has an effective system to monitor the administrative operations of the contractor, but it has not provided for effective (1) independent evaluation or (2) quality-of-care monitoring of the project. Similarly, FHC's system for assessing and authorizing care has many favorable features. However, several potential weaknesses exist that could affect access to and the quality of care received by CHAMPUS beneficiaries.

CHAMPUS Effectively Monitoring Administrative Operations

DOD, through CHAMPUS, provides effective monitoring of the administrative aspects of FHC's operations. CHAMPUS officials receive weekly and monthly progress reports from the project's contractor on various activities, such as claims adjudication timeliness, utilization of services, benefit costs, provider and beneficiary inquiries, and appeals of FHC decisions. Also, a CHAMPUS official makes regular visits to the project area and has almost daily telephone contact with contractor officials.

DOD Lacks an Overall Evaluation Plan

In contrast, when the project expires at the end of fiscal year 1993, DOD will have no overall evaluation of the project that addresses the fundamental question of whether the fixed-price model can reduce costs without causing access to care or quality treatment problems. Although DOD thoroughly evaluated the Sentara First Step contract, it decided to forgo evaluation of the FHC contract in 1989 because DOD believed that quality of care questions about the model had been sufficiently answered. However, DOD made this decision more than a year before the final evaluation of the Sentara First Step contract was published by Abt Associates (Abt).

DOD had contracted with Abt to collect and analyze cost, utilization, and quality data. Abt concluded in its final report, dated August 1, 1990, that the demonstration had succeeded in reducing costs. However, Abt was not able to conclusively answer questions about the project's impact on the quality of care, although Abt believed that the Sentara First Step model had not caused many quality treatment problems.

DOD's decision to forgo evaluation of the project may have been premature because several significant changes made to the contract model could have affected the quality of care provided. For example, under the Sentara First Step contract, the contractor had more direct involvement in the care provided to beneficiaries. Sentara First Step was required to work with area providers to develop mutually agreed upon treatment plans for inpatient and outpatient care, which included the most appropriate care setting. Currently, FHC unilaterally decides the care setting it will approve, while providers are responsible for developing a treatment plan to support the FHC care decision.

Also, until 1992, FHC's internal quality assurance functions and clinical operations (screening and level-of-care decisions) were part of the same organizational unit and management. Under the Sentara First Step contract, CHAMPUS separated the two functions to make quality assurance functions more independent. In 1992, at DOD's direction, FHC separated its quality assurance function from its clinical operations and instituted a number of quality assurance monitoring functions. These are positive changes; however, the impact of the previous organizational structure on quality has not been evaluated.

Systemetrics Reviews Are Limited and Findings Are Not Pursued

SysteMetrics has not been effectively used to determine whether beneficiaries received appropriate access to and quality of care. Under the current DOD contract, SysteMetrics regularly examines inpatient care, but

DOD does not require SysteMetrics to examine either the appropriateness of contractor decisions to provide outpatient care or the quality of the outpatient care that is provided, even though 87 percent of the contractor's authorization decisions are to provide outpatient care. SysteMetrics had these responsibilities under the Sentara First Step contract, but under the current contract, DOD has only authorized SysteMetrics to perform one outpatient study. It examined 134 outpatient cases, even though there have been more than 31,000 outpatient authorizations since FHC began operations.

On the other hand, SysteMetrics has regularly identified a number of potential inpatient quality-of-care problems, such as incomplete hospital discharge planning, suggested psychological testing not done, incorrect medications ordered by physicians, and diagnoses inconsistent with medical record documentation. However, neither the contractor nor DOD has followed up on these potential problems to determine the extent to which real problems are occurring. DOD officials attribute some of their inactivity to a lack of both clinical expertise in the CHAMPUS monitoring staff and procedures for taking action against problem providers.

Other Potential Access and Quality Treatment Problems Not Studied

DOD has not responded quickly to other indicators of potential access and quality treatment problems. For example, (1) FHC has identified 650 cases in which either the state of Virginia or local agencies in the Tidewater area had custody of DOD beneficiaries and in 95 cases provided financing for some or all of the care received; (2) Health Management Strategies International, the national mental health utilization review contractor for DOD, has identified over 500 cases where beneficiaries have left the project area to obtain care; (3) FHC and SysteMetrics have identified 109 beneficiaries who signed forms at hospitals giving up their rights to CHAMPUS benefits; and (4) CHAMPUS officials said that they were experiencing an 18-month backlog of beneficiary appeals at DOD, most concerning contractor denials of hospital admissions or continued hospital stays.

DOD officials suggested several reasons why these situations may have occurred, but they have not fully studied them to be certain nor always made appropriate changes. For example, CHAMPUS and FHC officials told us that they do not know how many of the 95 CHAMPUS beneficiaries are receiving state or local agency financed care due to FHC denying them inpatient services as opposed to those who are being provided care that is not covered by DOD.

Second, beneficiaries in the project area have the freedom to choose providers, including providers outside the project area. When beneficiaries leave the area, their care is managed by Health Management Strategies International. Although DOD has now researched many of these cases and found various reasons why beneficiaries left the area, it has not fully addressed beneficiaries' concerns, particularly those dealing with the project's strict criteria for approving residential treatment center care.

Third, some beneficiaries who have other health insurance have signed hospital forms waiving their CHAMPUS benefits as secondary coverage. DOD and FHC officials believe that beneficiaries sign these forms because of a desire to maintain secrecy about their mental health problem or to avoid FHC's scrutiny.

Finally, CHAMPUS officials stated that the project appeals backlog is due in part to a large number of appeals nationwide. For example, there was a total nationwide backlog of 3,702 mental health care appeals for fiscal years 1990 and 1991, including 250 in the project area. This nationwide appeals backlog makes it difficult to address project appeals in a timely fashion. Recent changes in the project should help to alleviate this problem (see p. 9).

Need to Improve Contractor Controls

Overall, the contractor's system for assessing and authorizing care provides reasonable assurance that beneficiaries can obtain access to the appropriate level of care. However, some contractor controls that affect the quality of care received by beneficiaries need to be strengthened. On the positive side, for example, the contractor provides personal (face-to-face) mental health assessments by experienced counselors; referrals of beneficiaries to a provider network; prospective reviews by licensed supervisors of all initial decisions to authorize or deny inpatient care; and monitoring of inpatient cases at the facility where care is being provided.

Yet contractor controls should be strengthened in two areas where care is sometimes unnecessarily delayed—inpatient and specialty care authorizations and emergency admissions—and in the documentation of some internal processes that could identify employee mistakes. Inpatient and specialty care is sometimes delayed when beneficiaries are incorrectly assessed by FHC as needing outpatient care. FHC does not prospectively review the appropriateness of outpatient authorizations made by its staff, as it does for inpatient authorizations. Instead, the control system depends

on the providers to identify and seek correction of some outpatient problems, such as inappropriate outpatient placements or an inappropriate clinical specialty for the mental health problem. Moreover, FHC does not track the extent to which beneficiaries are initially authorized outpatient care, but soon require a higher level of care.

Beneficiaries also experience some delays in obtaining needed care because of the criteria used in the project to determine a psychiatric emergency. Under project guidelines, beneficiaries in emergency situations can be admitted into a hospital without obtaining a face-to-face assessment by FHC. However, the project criteria restrict emergency admissions to severe life-threatening situations. Often, beneficiaries who leave a hospital's emergency room to go to FHC for assessment are judged to need inpatient hospitalization and must be taken back to a hospital. Concern about this process was the chief complaint of hospital officials and some beneficiaries because they believe it can be risky to transport patients in distress from one location to another.

Finally, contractor controls could be strengthened regarding documentation of FHC internal reviews of cases, which are designed to identify inappropriate care decisions made by its staff. Currently, licensed supervisors retrospectively review about 10 percent of all cases each month to assure that FHC staff are following the policies and procedures governing the authorization of care. However, the results of these reviews are not maintained after 4 months; thus, no statistical accumulation of the results exists to identify long-term trends or patterns. In addition, there is no clear indication of how these results are subsequently used to correct failures or errors in the system.

Recent Changes Should Improve Operations and Perceptions

DOD and FHC have implemented a number of project enhancements designed to improve the operations and perceptions of the project. For example, the appeals process has been streamlined to speed up decisions and reduce a backlog of cases, the contractor's internal quality assurance function has been made independent of clinical operations and decision making, a 24-hour on-call assessment service was provided at one remote hospital, and advisory boards were established to improve communications with beneficiaries and providers. However, the effect of these changes on the project remains to be seen.

Conclusions

The Contracted Provider Arrangement project in the Tidewater, Virginia, area has many positive features and strengths. It has saved the government money and tested new benefit options and ways to manage mental health care. However, we believe DOD lacks sufficient assurance that beneficiaries are receiving access to quality care because an overall plan to evaluate quality-of-care issues does not exist, potential quality-of-care problems identified have not been followed-up on, and some contractor quality-of-care controls need strengthening. While several of the problems we identified have been or are being addressed—as a result of congressional hearings, beneficiary complaints, DOD monitoring, and FHC's own assessments and initiatives—more actions are needed.

The project will expire at the end of September 1993, and it is uncertain what changes, if any, DOD will make. We believe, however, from a lessons-learned perspective, that quality of care issues should be fully resolved before DOD implements another program.

Recommendations

In designing future mental health care projects, the Secretary of Defense should direct the Assistant Secretary of Defense (Health Affairs) to:

- ensure that an effective independent quality-of-care monitor is established, and a system to follow-up on findings and implement corrective action is implemented;
- implement management controls to review and monitor the appropriateness of outpatient mental health care decisions;
- redefine "emergency admissions" so that CHAMPUS beneficiaries in crisis can be stabilized and obtain necessary assessments in an emergency department without leaving a hospital to have treatment assessments done by a contractor; and
- improve and maintain documentation of all internal processes designed to assure that appropriate decisions are being made and develop internal systems that document the use of internal quality assurance results to help identify potential failures or errors of the managed mental health care system.

As requested, we did not obtain written DOD comments on this report. However, we discussed the contents of a draft of this report with DOD officials. We made changes, where appropriate, based on their comments.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days from the date of this letter. At that time, we will send copies to the Secretary of Defense and to interested congressional committees. We will also make copies available to others on request. If you have any questions about this report, please call me on (202) 512-7101. Other major contributors are listed in appendix II.

David P. Baine

David P. Baine
Director, Federal Health
Care Delivery Issues

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Tables

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
FHC	First Hospital Corporation

Cost and Utilization Data for the Contracted Provider Arrangement Project

Partial hospitalization is a level of care between outpatient and inpatient care, in which beneficiaries spend a portion of each day in an inpatient setting. This level of care was not available to CHAMPUS beneficiaries in the Tidewater, Virginia, area before the Contracted Provider Arrangement project. In order to compare this project's inpatient utilization with predemonstration utilization, tables I.1 and I.2 display the project's utilization with and without partial hospitalization.

Table I.1: Cost and Utilization Data for the Contracted Provider Arrangement Project (Fiscal Years 1986 and 1991)

		Without partial hospitalization		With partial hospitalization	
	Fiscal year 1986	Fiscal year 1991	Percent change	Fiscal year 1991	Percent change
Inpatient[a]					
Admissions	2,284	1,270	-44	2,173	-5
Paid days	76,861	12,718	-83	22,041	-71
Benefit costs	$28,263,607	$3,781,314	-87	$4,704,098	-83
Admissions per 1,000 eligibles[b]	9.91	5.02	-49	8.60	-13
Avg. length of stay (days)	33.65	10.01	-70	10.14	-70
Cost per day	$367.72	$297.32	-19	$213.42	-42
Cost per admit	$12,374.61	$2,977.41	-76	$2,164.79	-83
Professional services	$3,395,656	$480,693	-86	$819,159	-76
Outpatient visits	117,648	204,517	+74	204,517	+74
Benefit cost	$5,758,914	$9,103,137	+59	$9,103,137	+59
Cost per visit	$48.78	$44.51	-9	$44.51	-9
Total costs	$37,418,177	$13,365,144	-64	$14,626,394	-61
Percent inpatient	85	32			38
Percent outpatient	15	68			62

[a]Includes residential treatment centers for children and adolescents.

[b]Number of eligibles is 230,360 for fiscal year 1986 and 252,778 for fiscal year 1991

Source: 1986 data from CHAMPUS; 1991 data from FHC.

Table I.2: CHAMPUS's Average Costs for Care, Nationwide and for Contracted Provider Arrangement Project
(Fiscal Year 1991)

		Contracted Provider Arrangement, without partial hospital		Contracted Provider Arrangement, with partial hospital	
	Nationwide costs	Costs	Percent change	Costs	Percent change
Inpatient daily reimbursement[a]	$374.85	$297.32	-21	$213.42	-43
Outpatient visits	$55.53	$44.51	-20	$44.51	-20

[a]Includes residential treatment centers for children and adolescents.

Source: National data from CHAMPUS; Contracted Provider Arrangement data from FHC.

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